UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION

BUTRANS (buprenorphine)

Patient name:_____Medicaid ID #:_____

Prescriber Name:_____Prescriber NPI#:_____ Contact person:_____

Prescriber Phone#:_____Extension/Option:_____ Fax#:_____

Pharmacy:_____Pharmacy Phone#:_____Pharmacy Fax #:_____

Requested Medication:_____Strength:_____Frequency/Day:_____

All information to be legible, complete and correct or form will be returned

---

FAX DOCUMENTATION FROM PROGRESS NOTES AND THIS COMPLETED FORM TO (801) 536-0477

CRITERIA:

- Minimum age requirement: 18 years old.
- Diagnosis of moderate to severe chronic pain requiring continuous, around-the-clock opioid analgesic for an extended period of time.
- Documented trial and failure of ≥ 1 oral non-opioid agent(s).
- Documented trial and failure of ≥ 1 oral opioid agent(s).

NOTES:

- Prior Authorization will be granted for up to 4 patches per 28 days. Additional quantities may be granted with satisfactory prescriber explanation during the first and last months of therapy to allow for dose titration.
- Butrans is only available to Traditional (purple card) Medicaid clients. Butrans is not a covered benefit for Non-Traditional Medicaid (blue card) or Primary Care Network (yellow card).

AUTHORIZATION:

Initial authorization period is for 3 months.

RE-AUTHORIZATION:

Reauthorization periods of up to one year require documentation that the patient is using the drug appropriately, and documentation of satisfactory pain control faxed to (801)536-0477.

2/16/11

http://health.utah.gov/medicaid/pharmacy